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Community Supported Agriculture

REGIONAL GOVERNANCE & RURAL HEALTH CARE
Wayne Myers MD
National Rural Health Assoc (Past Pres.), & RUPRI Fellow, 2006

Much of the “community” has gone out of America’s rural communities. One factor may be that Americans in general are becoming less involved in community activities, as discussed by Robert Putnam in his book, “Bowling Alone”. But it seems to me that another peculiarly rural factor is at work. My home town, Waldoboro Maine, is at the end of a large bundle of long tubes. Picture a fistful of soda straws, with our town at one end and the tubes stretching off hundreds of miles. The title of one tube is “television”; another is labeled “groceries”; “banking” is a third. All these tubes run up and away . They look pretty big around when you’re among them, so some people, particularly government workers, have come to refer to them as “silos”.

These tubes are “two way”. They deliver some product or service and extract something, generally money but in a few cases a commodity or natural resource. But these tubes or silos aren’t cross connected, at least at the bottom end where I live. The grocery store doesn’t buy and resell local groceries. The groceries are trucked into the region and the money is sent out. Television doesn’t show pictures of our main street. Bank officials at the top are probably unaware that there is a place called “Waldoboro”.

There are a few exceptions to this “tube” or “silo” pattern. There are still a few local and county newspapers. Health care is a bit of a hybrid, partially cross-connected, often isolated but learning to collaborate. That’s the one I want to talk about today.

Until recently most rural hospitals have been able to go broke. Hospital administrators prefer to complain about Medicare and other insurers not paying enough. But the real determinant of whether the hospital thrives or goes under is whether or not local people use it, and have some way of paying for their care. Certainly the hospital or clinic is connected to larger consultation, referral and transfer centers. Ideally these relationships work well enough to be called a regional system.

A health care facility can only be successful if local people trust it and use it as their point of contact with the regional system of care. That sort of trust and ownership will only be there if the clinic and hospital are connected with and responsive to the local people.

In an hypothetical small town a lot of health things are going on this February morning. An operating room supervisor from Big Regional Hospital is at Littletown Community Hospital helping train the staff on the use of new floor sanitizing agents. The hospital’s mobile unit is at the Court House doing mammograms. A consultant dermatologist and an orthopedic surgeon from Bigtown are seeing patients in the visiting doctors’ suite at

the hospital while a child and his family work with a pediatric neurologist over a telemedicine link. Staff of the Area Health Education Center are at school trying to interest seventh graders in health careers. They just ran into the mental health center's substance abuse counselor leaving the building after his session with the eighth graders. This afternoon they will visit a couple of local doctors who may be willing to take medical students into their practices for rural rotations. Two local vegetable farmers are calling on the hospital dietician and kitchen supervisor to see what produce the hospital may be able to buy next summer. From the hospital they will head to the nursing home. A lady who broke her hip last week is being transferred from Big Regional to Littletown Community Hospital for a few more days while she learns to get around and gets lined up with Home Health and physical therapy.

The local drug store is having a tough time in the face of the mail order outfits favored in the new Medicare law, but is holding on because people appreciate the personalized service and advice. The conversation at the drug store this morning centers on the wreck on the interstate last night and the helicopter transfer from the Littletown Community emergency room to Big Regional.

The hospital administrator is pushing hard to get out of her office to make the meeting of the internet-based Regional Health Information Organization, a "RHIO". The RHIO will make patients' medical records available wherever and whenever they're needed. From there she'll go to dinner with visiting officials of the wood products company who are in town looking at a plant site. Tomorrow morning starts early with a breakfast meeting of the medical staff with the sheriff, public health nurse and ambulance crew about methamphetamine issues. It occurs to her that this will probably be a more productive meeting than in the old days when the medical staff was all male and macho.

The ten thousand members of the National Rural Health Association include all the kinds of people involved in these activities, and more: state officials, university faculty, public health personnel and others. Health care makes up about one sixth of our total economy and workforce. It includes a hodge-podge of people. Accordingly, the NRHA finds itself working for the benefit of rural people in general. If a particular issue is of interest to only one group, it can't get much traction with the organization as a whole. NRHA works on a vision of healthy people in healthy rural communities. That collaborative vision extends to Washington where we work with the sixty-plus member groups of the National Rural Network. Our Rural Health Policy Institute in a couple weeks will include a session with USDA leadership on the Farm Bill. This breadth of concern seems to lend the Rural Health association some credibility with members of Congress. That credibility turned out to be important in the recent appropriation process.

American health care has two enormous problems: (1) It's dangerous and (2) it's outgrowing our economy's ability to pay for it. Medical mistakes are probably the eighth largest cause of death in the US. The quality issue has some special rural implications that may surprise you. The Institute of Medicine of the National Academy of Sciences recently published a report, "Quality through Collaboration, the Future of Rural Health". This is the latest in a series of reports on problems with the quality of American health

care. In it the Institute predicts that our quality problems can only be solved by strengthening the organization of health care systems, and that strengthening is more likely to start in rural communities than in the medical meccas. The reason for this prediction, and NRHA's National Quality Initiative, is straightforward. Rural regional healthcare includes a modest number of organizations. They're already acquainted and accustomed to working together. Building regional integrated information and quality improvement systems won't be easy but it's doable in predominantly rural areas. Trying to develop such systems in greater New York or Boston or LA is likely to be much harder.

Small rural hospitals now have the option of becoming "Critical Access Hospital". If your local hospital has less than 26 beds, it's probably a CAH. There are close to fourteen hundred of them. There are Medicare money advantages, but also special requirements. A Critical Access Hospital has to have formal working agreements with a larger general hospital for patient transfer, staff credentials and so forth. In addition the Federal Office of Rural Health Policy puts significant grant money into rural health network development. Collaboration pays.

In short, most of the organizational change in rural health care over the past fifteen years has been aimed at developing regional collaboration. Rural hospitals are learning that they must earn the trust and support of their communities to survive. We don't yet have sound reliable regional governance mechanisms. In some places the helicopter ambulance services have turned into astronomically expensive competitions. Some regional referral hospitals are more avaricious than collaborative. Sound regional collaboration depends on the special leadership and integrity of involved individuals. "One trick" hospitals and surgicenters are being built to skim off the profitable work and leave community facilities with the emergency care, charity and bad debt.. Health care is outgrowing the rest of the economy. These stresses will get more dangerous as financial pressures continue to build.

Health care is a regional function. In some cases it has helped develop new regional organizations and governance mechanisms. In other regions it suffers for the lack of such mechanisms. It has to learn more ways to get outside its own silo and connect with the community. There are lessons health care can teach, and others it needs to learn.

Thank you.

(1460 words)